Montgomery County Government
Summary of Benefits and Coverage (SBC)

Coverage 1/1/2015 – 12/31/2015

Contents:

The County expects to continue its group insurance plans, but it is the County's position that there is no implied contract to do so. The County reserves the right to change or discontinue any terms of the plans, subject to applicable laws and collective bargaining agreements. The County may amend the plans, either prospectively or retroactively, as required by Federal or State law. In the event of a conflict between this document, the County Code and/or the Summary Description, the County Code and then the Summary Description will govern. A paper copy of this document can be provided free of charge by contacting MC311 at 240-777-0311 (1-877-613-5212 toll free), or by visiting the Office of Human Resources, 101 Monroe St. (7th Floor), Executive Office Building, Rockville, MD 20850.

Caremark High Option
$4/8 and $5/10 Prescription Plans

Caremark High Option Prescription Plans

Summary of Benefits and Coverage: What these Plans Cover & What they Cost

Coverage Period: 01/01/2015 – 12/31/2015
Coverage for: Members | Plan Type: Rx

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.caremark.com** or by calling 1-866-240-4926.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Not applicable.	You must pay all the costs up to the **deductible** amount before these plans begin to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for *specific* services, but see the chart starting on page 2 for other costs for services these plans cover.
Is there an out–of–pocket limit on my expenses?	No	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Not applicable.	Not applicable.
Is there an overall annual limit on what these plans pay?	No	The chart starting on page 2 describes any limits on what these plans will pay for *specific* covered services.
Do these plans use a network of providers?	Yes, these plans use participating providers.	If you use a network provider, these plans will pay some or all of the costs of covered services. Plans use the term network, preferred, or participating for providers in their network.
Are there services these plans don't cover?	Yes	Some of the services these plans don't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-866-240-4926 or visit www.caremark.com. If you aren't clear about any of the bolded terms used in this form, see the Glossary at www.healthcare.gov/glossary.

- **Co-payments (copays)** are fixed dollar amounts (for example, $10) you pay for covered health care, usually when you receive the service.

Common Medical Event	Services You May Need	Your cost if you are a member of: $4/$8 High Option Plan *(IAFF & MCGEO)*	Your cost if you are a member of: $5/$10 High Option Plan *(unrepresented, FOP & retirees)*	Notes, Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Tier 1- Your lowest cost option (generic drugs or brand name drugs that do not have a generic available)	Retail: $4 copay Mail Order: $4 copay	Retail: $5 copay Mail Order: $5 copay	**Retail Pharmacy Network:** To purchase up to a 30-day supply of a short-term medication, use your Caremark member ID card at a participating retail pharmacy. **Maintenance Choice®:** To purchase up to a 90-day supply of a maintenance medication, use your Caremark member ID card at a CVS/pharmacy retail location or use Caremark's Mail Service Pharmacy. **Important:** If you fill a 30-day prescription for a maintenance medication at a participating retail pharmacy more than two times (original fill plus one refill), you pay the copayment *plus* the cost difference between mail service and retail pharmacy each time you fill the prescription thereafter. To avoid this, submit a 90-day script with 3 refills through Maintenance Choice (either at a CVS/pharmacy retail location or through mail service). **For brand name drugs that have a generic available,** your copay is $8 or $10 (depending on your Plan) if you have an approved letter of medical necessity on file with Caremark. (If not, the cost is $4 or $5 *plus* the difference between the brand name and generic drug costs.)
	Tier 2 – Your highest cost option (brand name drugs that have a generic available)	Retail: $8 copay Mail Order: $8 copay	Retail: $10 copay Mail Order: $10 copay	

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**
Caremark's quarterly Preferred Drug List is available at www.montgomerycountymd.gov/ohr; click the Benefits tab and then the appropriate Health Insurance page; scroll down to the Prescription Plan Caremark Materials section.
Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**
Not applicable.

Your Rights to Continue Coverage:

Group health coverage: If you lose coverage under your plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plans at 1-866-240-4926. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact the Member Service number listed on the back of your ID card or visit www.caremark.com. Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http:///ciio.cms.gov/prgrams/consumer/capgrants/index.html.

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Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

What happens if I am eligible for Medicare?

If you are eligible for Medicare (including due to disability) and elect to participate in the Caremark High Option Prescription Plan, you automatically will participate in Part D, which is administered by SilverScript. You are not eligible for Medicare Part D and the County's Prescription Plan if you (a) have an international address; (b) do not have Medicare Part A and/or Part B; (c) are incarcerated.

Important: Medicare is required to give a 21-day period in order to permit you to opt out of the program. However, if you opt out, you will not have any prescription drug coverage through the County's Prescription Plans.

Are my benefits the same if I am enrolled in Medicare Part D through the County?

The Caremark High Option Prescription Plan coordinates around Medicare to provide prescription drug coverage. Under the coordination with Medicare, all aspects of the Caremark High Option Prescription Plan are as described in this document and under the Prescription Plan in the Group Insurance Summary Description (available online at http://www.montgomerycountymd.gov/ohr/benefits/rgi/retireebenefits.html).

Are my overall costs the same if I am enrolled in Medicare Part D through the County?

Under Medicare, if you pay an income based adjusted premium, you will also pay an additional amount for Part D as described on the Medicare website (www.medicare.gov).

Where can I find more information?

Visit http://www.montgomerycountymd.gov/ohr/benefits/rgi/egwp.html or refer to the Group Insurance Summary Description at http://www.montgomerycountymd.gov/ohr/benefits/rgi/retireebenefits.html).

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Caremark Standard Option Prescription Plan

Caremark Standard Option Prescription Plan

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2015 – 12/31/2015
Coverage for: Member | **Plan Type: Rx**

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.caremark.com** or by calling **1-866-240-4926.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$50 individual or family Per calendar year	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for *specific* services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	No	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Not applicable.	Not applicable.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services.
Does this plan use a network of providers?	Yes, this plan uses participating providers.	If you use a network provider, this plan will pay some or all of the costs of covered services. Plans use the term network, preferred, or participating for providers in their network.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-866-240-4926 or visit www.caremark.com**.** If you aren't clear about any of the bolded terms used in this form, see the Glossary at www.healthcare.gov/glossary.

Co-payments (copays) are fixed dollar amounts (for example, $10) you pay for covered health care, usually when you receive the service.

Common Medical Event	Services You May Need	Your cost if you use a		Notes, Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com .	Tier 1- Your lowest cost option (generic drugs)	Retail: $10 copay Mail Order: $10 copay	Not applicable	Caremark's quarterly Preferred Drug List is available at www.montgomerycountymd.gov/ohr; click the Benefits tab and then the appropriate Health Insurance page; scroll down to the Prescription Plan Caremark Materials section. **Retail Pharmacy Network:** To purchase up to a 30-day supply of a short-term medication, use your Caremark member ID card at a participating retail pharmacy. **Maintenance Choice®:** To purchase up to a 90-day supply of a maintenance medication, use your Caremark member ID card at a CVS/pharmacy retail location or use Caremark's Mail Service Pharmacy. **Important:** If you fill a 30-day prescription for a maintenance medication at a participating retail pharmacy more than two times (original fill plus one refill), you pay the copayment *plus* the cost difference between mail service and retail pharmacy each time you fill the prescription thereafter. To avoid this, submit a 90-day script with 3 refills through Maintenance Choice (either at a CVS/pharmacy retail location or through mail service). **For brand name drugs that have a generic available**, your copay is $20 or $35, if you have an approved letter of medical necessity on file with Caremark. (If not, the cost is $10 *plus* the difference between the brand name and generic drug costs.)
	Tier 2 – Your mid-range cost option (brand name drugs on Caremark's Preferred Drug List with no generic available)	Retail: $20 copay Mail Order: $20 copay	Not applicable	
	Tier 3 – Your highest cost option (brand name drugs *not* on Caremark's Preferred Drug List with no generic available)	Retail: $35 copay Mail Order: $35 copay	Not applicable	

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**
Caremark's quarterly Preferred Drug List is available at www.montgomerycountymd.gov/ohr; click the Benefits tab and then the appropriate Health Insurance page; scroll down to the Prescription Plan Caremark Materials section.
Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**
Not applicable

Your Rights to Continue Coverage:

Group health coverage: If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-240-4926. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact the Member Service number listed on the back of your ID card or visit www.caremark.com. Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http:///ciio.cms.gov/prgrams/consumer/capgrants/index.html.

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Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

What happens if I am eligible for Medicare?

If you are eligible for Medicare (including due to disability) and elect to participate in the Caremark Standard Option Prescription Plan, you automatically will participate in Part D, which is administered by SilverScript. You are not eligible for Medicare Part D and the County's Prescription Plan if you (a) have an international address; (b) do not have Medicare Part A and/or Part B; (c) are incarcerated.

Important: Medicare is required to give a 21-day period in order to permit you to opt out of the program. However, if you opt out, you will not have any prescription drug coverage through the County's Prescription Plans.

Are my benefits the same if I am enrolled in Medicare Part D through the County?

The Caremark Standard Option Prescription Plan coordinates around Medicare to provide prescription drug coverage. Under the coordination with Medicare, all aspects of the Caremark Standard Option Prescription Plan are as described in this document and under the Prescription Plan in the Group Insurance Summary Description (available online at http://www.montgomerycountymd.gov/ohr/benefits/rgi/retireebenefits.html).

Are my overall costs the same if I am enrolled in Medicare Part D through the County?

Under Medicare, if you pay an income based adjusted premium, you will also pay an additional amount for Part D as described on the Medicare website (www.medicare.gov).

Where can I find more information?

Visit http://www.montgomerycountymd.gov/ohr/benefits/rgi/egwp.html or refer to the Group Insurance Summary Description at http://www.montgomerycountymd.gov/ohr/benefits/rgi/retireebenefits.html).

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CareFirst BlueCross BlueShield
Point of Service High Option
In Service Area Plan

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.carefirst.com or by calling 1-888-417-8385.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For Non-Participating Providers: $300 Individual/$600 Family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	For Participating Providers: $1,000 Individual For Non-Participating Providers: $1,000 Individual	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Deductibles, copayments, premiums, balance-billed charges (unless balanced billing is prohibited), and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. For a definition of balance billing, see the third bullet at the top of page 2.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. Please visit www.CareFirst.com or call 1-855-258-6518 for a listing of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

Questions: 1-888-417-8385 www.carefirst.com**.** If you aren't clear about any of the bolded terms used in this form, see the Glossary at www.carefirst.com/sbcg.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay	20% coinsurance subject to deductible	none
	Specialist visit	$10 copay	20% coinsurance subject to deductible	none
	Other practitioner office visit	No deductible, copay and coinsurance for Chiropractic Services $10 copay for Acupuncture Services	20% coinsurance subject to deductible for Chiropractic and Acupuncture Services	none
	Preventive care/screening/immunization	$10 copay	20% coinsurance for Well Child Exam 20% coinsurance subject to deductible for Adult Physical Exam	none
If you have a test	Diagnostic test (x-ray, blood work)	No deductible, copay and coinsurance	20% coinsurance	none
	Imaging (CT/PET scans, MRIs)	No deductible, copay and coinsurance	20% coinsurance subject to deductible	none

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carefirst.com **Important:** Diabetic Supplies will be covered under your medical benefits	Generic drugs	Not Covered	Not Covered	No Coverage for prescription drugs with Carefirst except for Diabetic Supplies
	Preferred brand drugs	Not Covered	Not Covered	No Coverage for prescription drugs with Carefirst except for Diabetic Supplies
	Non-preferred brand drugs	Not Covered	Not Covered	No Coverage for prescription drugs with Carefirst except for Diabetic Supplies
	Specialty drugs	Not Covered	Not Covered	No Coverage for prescription drugs with Carefirst except for Diabetic Supplies
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No deductible, copay and coinsurance	20% coinsurance subject to deductible	none
	Physician/surgeon fees	No deductible, copay and coinsurance	20% coinsurance subject to deductible	none
If you need immediate medical attention	Emergency room services	$25 copay	$25 copay	Copay waived if admitted
	Emergency medical transportation	No deductible, copay and coinsurance	No deductible, copay and coinsurance	none
	Urgent care	$10 copay	20% coinsurance subject to deductible	none
If you have a hospital stay	Facility fee (e.g., hospital room)	No deductible, copay and coinsurance	20% coinsurance subject to deductible	Preauthorization required
	Physician/surgeon fee	No deductible, copay and coinsurance	20% coinsurance subject to deductible	none

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have mental health, behavioral health, or substance abuse needs you must use a Magellan Behavioral Health Network Provider (1-800-245-7013 or www.magellanassist.com) to receive in-network benefits.	Mental/Behavioral health outpatient services	$10 Copay	20% coinsurance subject to deductible	none
	Mental/Behavioral health inpatient services	No deductible, copay and coinsurance	20% coinsurance subject to deductible	Preauthorization required
	Substance use disorder outpatient services	$10 Copay	20% coinsurance subject to deductible	none
	Substance use disorder inpatient services	No deductible, copay and coinsurance	20% coinsurance subject to deductible	Preauthorization required
If you are pregnant	Prenatal and postnatal care	No deductible, copay and coinsurance	20% coinsurance subject to deductible	none
	Delivery and inpatient services	No deductible, copay and coinsurance	20% coinsurance subject to deductible	none
If you need help recovering or have other special health needs	Home health care	No deductible, copay and coinsurance	20% coinsurance subject to deductible	90 visits per calendar year
	Rehabilitation services	No deductible, copay and coinsurance	20% coinsurance subject to deductible	Rehabilitation Services include Physical, Occupational and Speech Therapies Limited to 90 visits each per calendar year
	Habilitation services	No deductible, copay and coinsurance	20% coinsurance subject to deductible	none
	Skilled nursing care	No deductible, copay and coinsurance	20% coinsurance subject to deductible	100 days per calendar year
	Durable medical equipment	No deductible, copay and coinsurance	20% coinsurance subject to deductible	none
	Hospice service	No deductible, copay and coinsurance	20% coinsurance subject to deductible	none
If you need dental or eye care	Eye exam	Not Covered	Not Covered	Covered only if medically necessary

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
	Glasses	Not Covered	Not Covered	Covered only if medically necessary
	Dental	Not Covered	Not Covered	Covered only if medically necessary

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Hearing aids (Adult)
- Long-term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture (if prescribed for rehabilitation purposes)
- Bariatric surgery
- Chiropractic care
- Infertility treatment
- Most coverage provided outside the United States. See www.carefirst.com
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

Your Rights to Continue Coverage:

**** Group health coverage–**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-417-8385. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: www.carefirst.com or 1-888-417-8385. You may also contact state consumer Assistance Program

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-258-6518

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-258-6518

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-258-6518

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-258-6518

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,330
- **Patient pays** $210

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$60
Co-pays	$0
Co-insurance	$0
Limits or exclusions	$150
Total	**$210**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,580
- **Patient pays** $820

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$300
Copays	$400
Coinsurance	$0
Limits or exclusions	$80
Total	**$820**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: 1-888-417-8385 www.carefirst.com**.** If you aren't clear about any of the bolded terms used in this form, see the Glossary at **www.carefirst.com/sbcg.** CareFirst's role is limited to the provision of administrative services only and that CareFirst assumes no financial responsibility for claims arising from these described benefits

CareFirst BlueCross BlueShield
Point of Service Standard Option
In Service Area Plan

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.carefirst.com or by calling 1-888-417-8385.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For Non-Participating Providers: $300 Individual/$600 Family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	For Participating Providers: $1,000 Individual For Non-Participating Providers: $1,000 Individual	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Copayments, premiums, balance-billed charges (unless balanced billing is prohibited), and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. For a definition of balance billing, see the third bullet at the top of page 2.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. Please visit www.CareFirst.com or call 1-855-258-6518 for a listing of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay	20% coinsurance subject to deductible	none
	Specialist visit	$30 copay	20% coinsurance subject to deductible	none
	Other practitioner office visit	No deductible, copay and coinsurance for Chiropractic Services $15 copay/PCP $30 copay/Specialist for Acupuncture Services	20% coinsurance subject to deductible for Chiropractic and Acupuncture Services	none
	Preventive care/screening/immunization	$15 copay/PCP $30 copay/Specialist	20% coinsurance subject to deductible	none
If you have a test	Diagnostic test (x-ray, blood work)	No deductible, copay and coinsurance	20% coinsurance	none
	Imaging (CT/PET scans, MRIs)	No deductible, copay and coinsurance	20% coinsurance subject to deductible	none

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carefirst.com **Important:** Diabetic Supplies will be covered under your medical benefits	Generic drugs	Not Covered	Not Covered	No Coverage for prescription drugs with Carefirst except for Diabetic Supplies
	Preferred brand drugs	Not Covered	Not Covered	No Coverage for prescription drugs with Carefirst except for Diabetic Supplies
	Non-preferred brand drugs	Not Covered	Not Covered	No Coverage for prescription drugs with Carefirst except for Diabetic Supplies
	Specialty drugs	Not Covered	Not Covered	No Coverage for prescription drugs with Carefirst except for Diabetic Supplies
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No deductible, copay and coinsurance	20% coinsurance subject to deductible	——————none——————
	Physician/surgeon fees	No deductible, copay and coinsurance	20% coinsurance subject to deductible	——————none——————
If you need immediate medical attention	Emergency room services	$35 copay	$35 copay	Copay waived if admitted
	Emergency medical transportation	No deductible, copay and coinsurance	No deductible, copay and coinsurance	——————none——————
	Urgent care	$30 copay	20% coinsurance subject to deductible	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	$150 per admission copay	20% coinsurance subject to deductible	Preauthorization required
	Physician/surgeon fee	No deductible, copay and coinsurance	20% coinsurance subject to deductible	——————none——————

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have mental health, behavioral health, or substance abuse needs you must use a Magellan Behavioral Health Network Provider (1-800-245-7013 or www.magellanassist.com) to receive in-network benefits.	Mental/Behavioral health outpatient services	$15 copay	20% coinsurance subject to deductible	——————none——————
	Mental/Behavioral health inpatient services	$150 per admission copay	20% coinsurance subject to deductible	Preauthorization required.
	Substance use disorder outpatient services	$15 copay	20% coinsurance subject to deductible	——————none——————
	Substance use disorder inpatient services	$150 per admission copay	20% coinsurance subject to deductible	Preauthorization required.
If you are pregnant	Prenatal and postnatal care	No deductible, copay and coinsurance	20% coinsurance subject to deductible	——————none——————
	Delivery and inpatient services	$150 per admission copay	20% coinsurance subject to deductible	——————none——————
If you need help recovering or have other special health needs	Home health care	No deductible, copay and coinsurance	20% coinsurance subject to deductible	90 visits per calendar year
	Rehabilitation services	No deductible, copay and coinsurance	20% coinsurance subject to deductible	Rehabilitation Services include Physical, Occupational and Speech Therapies Limited to 90 visits each per calendar year
	Habilitation services	No deductible, copay and coinsurance	20% coinsurance subject to deductible	——————none——————
	Skilled nursing care	No deductible, copay and coinsurance	20% coinsurance subject to deductible	100 days per calendar year
	Durable medical equipment	No deductible, copay and coinsurance	20% coinsurance subject to deductible	——————none——————
	Hospice service	No deductible, copay and coinsurance	20% coinsurance subject to deductible	——————none——————
If you need dental or eye care	Eye exam	Not Covered	Not Covered	Covered if medically necessary
	Glasses	Not Covered	Not Covered	Covered if medically necessary
	Dental check up	Not Covered	Not Covered	Covered if medically necessary

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture (if prescribed for rehabilitation purposes) • Cosmetic surgery	• Dental care (Adult) • Hearing aids (Adult) • Long-term care	• Routine eye care (Adult) • Routine foot care • Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Bariatric surgery • Chiropractic care	• Infertility treatment • Most coverage provided outside the United States. See www.carefirst.com	• Non-emergency care when traveling outside the U.S. • Private-duty nursing

Your Rights to Continue Coverage:

**** Group health coverage–**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-417-8385. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: www.carefirst.com or 1-888-417-8385. You may also contact state consumer Assistance Program

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-258-6518

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-258-6518

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-258-6518

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-258-6518

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,930
- **Patient pays** $610

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$300
Co-pays	$160
Co-insurance	$0
Limits or exclusions	$150
Total	**$610**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,510
- **Patient pays** $890

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$300
Copays	$510
Coinsurance	$0
Limits or exclusions	$80
Total	**$890**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: 1-888-417-8385. www.carefirst.com. If you aren't clear about any of the bolded terms used in this form, see the Glossary at www.carefirst.com/sbcg.. CareFirst's role is limited to the provision of administrative services only and that CareFirst assumes no financial responsibility for claims arising from these described benefits

CareFirst BlueCross BlueShield
Point of Service High Option
Out of Area Plan

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.carefirst.com or by calling 1-888-417-8385.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For Preferred Providers: $0 For Non-Participating Providers: $250 Individual/$500 Family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	For Preferred Providers: $1,000 Individual/$2,000 Family For Non-Participating Providers: $2,000 Individual/$4,000 Family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges (unless balanced billing is prohibited), and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. For a definition of balance billing, see the third bullet at the top of page 2.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. Please visit www.CareFirst.com or call 1-855-258-6518 for a listing of preferred providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

Questions: 1-888-417-8385 www.carefirst.com. If you aren't clear about any of the bolded terms used in this form, see the Glossary at www.carefirst.com.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay	20% coinsurance subject to deductible	none
	Specialist visit	$10 copay	20% coinsurance subject to deductible	none
	Other practitioner office visit	No deductible, copay and coinsurance for Chiropractic and Acupuncture Services	20% coinsurance subject to deductible for Chiropractic and Acupuncture Services	Acupuncture is covered by a physician, when used as an anesthetic
	Preventive care/screening/immunization	$10 copay	20% coinsurance for Well Child Exam 20% coinsurance subject to deductible for Adult Physical Exam	none
If you have a test	Diagnostic test (x-ray, blood work)	No deductible, copay and coinsurance	20% coinsurance subject to deductible	none
	Imaging (CT/PET scans, MRIs)	No deductible, copay and coinsurance	20% coinsurance subject to deductible	none

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.Carefirst.com **Important:** Diabetic Supplies will be covered under your medical benefits	Generic drugs	Not Covered	Not Covered	No Coverage for prescription drugs with Carefirst except for Diabetic Supplies
	Preferred brand drugs	Not Covered	Not Covered	No Coverage for prescription drugs with Carefirst except for Diabetic Supplies
	Non-preferred brand drugs	Not Covered	Not Covered	No Coverage for prescription drugs with Carefirst except for Diabetic Supplies
	Specialty drugs	Not Covered	Not Covered	No Coverage for prescription drugs with Carefirst except for Diabetic Supplies
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No deductible, copay and coinsurance	20% coinsurance subject to deductible	none
	Physician/surgeon fees	No deductible, copay and coinsurance	20% coinsurance subject to deductible	none
If you need immediate medical attention	Emergency room services	$50 copay	$50 copay	Copay waived if admitted
	Emergency medical transportation	No deductible, copay and coinsurance	No deductible, copay and coinsurance	none
	Urgent care	$10 copay	20% coinsurance subject to deductible	none
If you have a hospital stay	Facility fee (e.g., hospital room)	No deductible, copay and coinsurance	20% coinsurance subject to deductible	Preauthorization required
	Physician/surgeon fee	No deductible, copay and coinsurance	20% coinsurance subject to deductible	none

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have mental health, behavioral health, or substance abuse needs you must use a Magellan Behavioral Health Network Provider (1-800-245-7013 or www.magellanassist.com) to receive in-network benefits.	Mental/Behavioral health outpatient services	$10 copay	20% coinsurance subject to deductible	none
	Mental/Behavioral health inpatient services	No deductible, copay and coinsurance	20% coinsurance subject to deductible	Preauthorization required.
	Substance use disorder outpatient services	$10 copay	20% coinsurance subject to deductible	none
	Substance use disorder inpatient services	No deductible, copay and coinsurance	20% coinsurance subject to deductible	Preauthorization required.
If you are pregnant	Prenatal and postnatal care	No deductible, copay and coinsurance	20% coinsurance subject to deductible	none
	Delivery and inpatient services	No deductible, copay and coinsurance	20% coinsurance subject to deductible	none
If you need help recovering or have other special health needs	Home health care	No deductible, copay and coinsurance	20% coinsurance subject to deductible	40 days per calendar year
	Rehabilitation services	No deductible, copay and coinsurance	20% coinsurance subject to deductible	Rehabilitation Services include Physical, Occupational and Speech Therapies
	Habilitation services	No deductible, copay and coinsurance	20% coinsurance subject to deductible	Preauthorization required after the first visit
	Skilled nursing care	No deductible, copay and coinsurance	20% coinsurance subject to deductible	60 days per calendar year
	Durable medical equipment	$10 copay	20% coinsurance subject to deductible	none
	Hospice service	No deductible, copay and coinsurance	20% coinsurance subject to deductible	none
If you need dental or eye care	Eye exam	Not Covered	Not Covered	Covered if medically necessary
	Glasses	Not Covered	Not Covered	Covered if medically necessary
	Dental check up	Not Covered	Not Covered	Covered if medically necessary

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture (if prescribed for rehabilitation purposes) • Cosmetic surgery	• Dental care (Adult) • Hearing aids (Adult) • Long-term care	• Routine eye care (Adult) • Routine foot care • Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Bariatric surgery • Chiropractic care	• Infertility treatment • Most coverage provided outside the United States. See www.carefirst.com	• Non-emergency care when traveling outside the U.S. • Private-duty nursing

Your Rights to Continue Coverage:

**** Group health coverage–**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-417-8385. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: www.carefirst.com or 1-888-417-8385. You may also contact state consumer Assistance Program

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-258-6518

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-258-6518

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-258-6518

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-258-6518

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,360
- **Patient pays** $180

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Co-pays	$30
Co-insurance	$0
Limits or exclusions	$150
Total	**$180**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,560
- **Patient pays** $840

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$760
Coinsurance	$0
Limits or exclusions	$80
Total	**$840**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: 1-888-417-8385. www.carefirst.com. If you aren't clear about any of the bolded terms used in this form, see the Glossary at **www.carefirst.com/sbcg.** CareFirst's role is limited to the provision of administrative services only and that CareFirst assumes no financial responsibility for claims arising from these described benefits

CareFirst BlueCross BlueShield
Point of Service Standard Option
Out of Area Plan

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.carefirst.com or by calling 1-888-417-8385.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For Preferred Providers: $0 For Non-Participating Providers: $250 Individual/$500 Family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	For Preferred Providers: $1,000 Individual/$2,000 Family For Non-Participating Providers: $2,000 Individual/$4,000 Family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges (unless balanced billing is prohibited), and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. For a definition of balance billing, see the third bullet at the top of page 2.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. Please visit www.CareFirst.com or call 1-855-258-6518 for a listing of preferred providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

Questions: 1-888-417-8385. www.carefirst.com. If you aren't clear about any of the bolded terms used in this form, see the Glossary at www.carefirst.com/sbcg.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay	20% coinsurance subject to deductible	none
	Specialist visit	$30 copay	20% coinsurance subject to deductible	none
	Other practitioner office visit	No deductible, copay and coinsurance for Chiropractic and Acupuncture Services	20% coinsurance subject to deductible for Chiropractic and Acupuncture Services	Acupuncture is covered by a physician, when used as an anesthetic
	Preventive care/screening/immunization	$15 copay/PCP $30 copay/Specialist	20% coinsurance for Well Child Exam 20% coinsurance subject to deductible for Adult Physical Exam	none
If you have a test	Diagnostic test (x-ray, blood work)	No deductible, copay and coinsurance	20% coinsurance subject to deductible	none
	Imaging (CT/PET scans, MRIs)	No deductible, copay and coinsurance	20% coinsurance subject to deductible	none

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carefirst.com **Important:** Diabetic Supplies will be covered under your medical benefits	Generic drugs	Not Covered	Not Covered	No Coverage for prescription drugs with Carefirst except for Diabetic Supplies
	Preferred brand drugs	Not Covered	Not Covered	No Coverage for prescription drugs with Carefirst except for Diabetic Supplies
	Non-preferred brand drugs	Not Covered	Not Covered	No Coverage for prescription drugs with Carefirst except for Diabetic Supplies
	Specialty drugs	Not Covered	Not Covered	No Coverage for prescription drugs with Carefirst except for Diabetic Supplies
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No deductible, copay and coinsurance	20% coinsurance subject to deductible	——————none——————
	Physician/surgeon fees	No deductible, copay and coinsurance	20% coinsurance subject to deductible	——————none——————
If you need immediate medical attention	Emergency room services	$50 copay	$50 copay	Copay waived if admitted
	Emergency medical transportation	No deductible, copay and coinsurance	No deductible, copay and coinsurance	——————none——————
	Urgent care	$30 copay	20% coinsurance subject to deductible	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	$150 per admission copay	20% coinsurance subject to deductible	Preauthorization required
	Physician/surgeon fee	No deductible, copay and coinsurance	20% coinsurance subject to deductible	——————none——————

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have mental health, behavioral health, or substance abuse needs you must use a Magellan Behavioral Health Network Provider (1-800-245-7013 or www.magellanassist.com) to receive in-network benefits.	Mental/Behavioral health outpatient services	$15 copay	20% coinsurance subject to deductible	none
	Mental/Behavioral health inpatient services	$150 per admission copay	20% coinsurance subject to deductible	Preauthorization required
	Substance use disorder outpatient services	$15 copay	20% coinsurance subject to deductible	none
	Substance use disorder inpatient services	$150 per admission copay	20% coinsurance subject to deductible	Preauthorization required
If you are pregnant	Prenatal and postnatal care	No deductible, copay and coinsurance	20% coinsurance subject to deductible	none
	Delivery and inpatient services	$150 per admission copay	20% coinsurance subject to deductible	none
If you need help recovering or have other special health needs	Home health care	No deductible, copay and coinsurance	20% coinsurance subject to deductible	40 days per calendar year
	Rehabilitation services	No deductible, copay and coinsurance	20% coinsurance subject to deductible	Rehabilitation Services include Physical, Occupational and Speech Therapies
	Habilitation services	No deductible, copay and coinsurance	20% coinsurance subject to deductible	Preauthorization required after the first visit
	Skilled nursing care	No deductible, copay and coinsurance	20% coinsurance subject to deductible	60 days per calendar year
	Durable medical equipment	$15 copay/PCP $30 copay/Specialist	20% coinsurance subject to deductible	none
	Hospice service	No deductible, copay and coinsurance	20% coinsurance subject to deductible	none
If you need dental or eye care	Eye exam	Not Covered	Not Covered	Covered only if medically necessary

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
	Glasses	Not Covered	Not Covered	Covered only if medically necessary
	Dental check up	Not Covered	Not Covered	Covered only if medically necessary

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture (if prescribed for rehabilitation purposes)
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids (Adult)
- Long-term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Bariatric surgery
- Chiropractic care
- Infertility treatment
- Most coverage provided outside the United States. See: www.carefirst.com
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

Your Rights to Continue Coverage:

**** Group health coverage–**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-417-8385. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: www.carefirst.com or 1-888-417-8385. You may also contact state consumer Assistance Program

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC – 1-877-685-6391 or www.disb.dc.gov
- Virginia – 1-877-310-6560 or www.scc.virginia.gov/boi

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-258-6518

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-258-6518

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-258-6518

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-258-6518

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,200
- **Patient pays** $340

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Co-pays	$190
Co-insurance	$0
Limits or exclusions	$150
Total	**$340**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,440
- **Patient pays** $960

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$880
Coinsurance	$0
Limits or exclusions	$80
Total	**$960**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: 1-888-417-8385 www.carefirst.com**.** If you aren't clear about any of the bolded terms used in this form, see the Glossary at **www.carefirst.com/sbcg.** CareFirst's role is limited to the provision of administrative services only and that CareFirst assumes no financial responsibility for claims arising from these described benefits

United Healthcare HMO
(Select EPO Network)

UnitedHealthcare

Montgomery County Government Medical Plan

Coverage Period: 01/01/2015 – 12/31/2015

Summary of Benefits and Coverage: What This Plan Covers & What it Costs **Coverage for:** Employee & Family **Plan Type:** HMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at welcometouhc.com or by calling 1-800-638-0014.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0**	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet **deductible** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Network: **$1,100** Individual / **$3,600** Family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	**Premium**, prescription drugs, copays, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes, For a list of **network providers, see** myuhc.com or call **1-800-638-0014.**	If you use a network doctor or other health care **provider,** this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred,** or participating for **providers** in their **network** See the chart starting on page 2 for how this plan pays different kinds of **providers.**
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-800-638-0014 or visit us at welcometouhc.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf or call the phone number above to request a copy.

Summary of Benefits and Coverage: What This Plan Covers & What it Costs **Coverage for:** Employee & Family **Plan Type:** HMO

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If a non-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a non-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$5 copay per visit	Not Covered	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	$10 copay per visit	Not Covered	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	50% co-ins for manipulative (Chiropractic) services	Not Covered	Benefits include diagnosis and related services and are limited to one visit and treatment per day. Limited to 24 visits of manipulative (Chiropractic) services per calendar year.
	Preventive care / screening / immunization	$5 copay per visit $10 copay per visit for specialist	Not Covered	No coverage non-network.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	None
	Imaging (CT / PET scans, MRIs)	No Charge	Not Covered	None

Summary of Benefits and Coverage: What This Plan Covers & What it Costs **Coverage for:** Employee & Family **Plan Type:** HMO

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition **Important:** Pharmacy Benefits for Diabetic Supplies Only.	Tier 1 – Your Lowest-Cost Option	Retail: $5 copay Mail-Order: $12.50 copay	Not Covered	No coverage for prescription drugs with UnitedHealthcare except for Diabetic Supplies
	Tier 2 – Your Midrange-Cost Option	Retail: $20 copay Mail-Order: $50 copay	Not Covered	
	Tier 3 – Your Highest-Cost Option	Not Applicable	Not Applicable	
	Tier 4 – Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$25 copay per visit	Not Covered	None
	Physician / surgeon fees	No Charge	Not Covered	None
If you need immediate medical attention	Emergency room services	$25 copay per visit	Same as network	Copay is waived if you are admitted for an Inpatient Stay directly from the Emergency Room.
	Emergency medical transportation	No Charge	No Charge	None
	Urgent care	$15 copay per visit	Not Covered	If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.

Summary of Benefits and Coverage: What This Plan Covers & What it Costs **Coverage for:** Employee & Family **Plan Type:** HMO

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	Prior Notification is required for certain services.
	Physician / surgeon fees	No Charge	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	$5 copay per visit	Not Covered	None
	Mental / Behavioral health inpatient services	No Charge	Not Covered	Prior Notification is required for certain services.
	Substance use disorder outpatient services	$5 copay per visit	Not Covered	None
	Substance use disorder inpatient services	No Charge	Not Covered	Prior Notification is required for certain services.
If you are pregnant	Prenatal and postnatal care	$5 copay for initial visit	Not Covered	Additional copays, deductibles, or co-ins may apply depending on services rendered.
	Delivery and all inpatient services	No Charge	Not Covered	Prior Notification is required for inpatient stays greater than 48 hours following a normal delivery and 96 hours following a cesarean section delivery.
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Limited to 60 visits for skilled care services per Calendar year. Prior Notification is required for certain services.
	Rehabilitation services	$10 copay per outpatient visit	Not Covered	Limits per Calendar year: 60 combined visits of physical, speech, occupational; cardiac – Unlimited visits; pulmonary – Unlimited visits.

Summary of Benefits and Coverage: What This Plan Covers & What it Costs **Coverage for:** Employee & Family **Plan Type:** HMO

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Habilitative services	$10 copay per outpatient visit	Not Covered	Limits are combined with Rehabilitation Services limits listed above. Benefits are limited to children under age 19 for the treatment of a child with a congenital or genetic birth defect to enhance a child's ability to function except for early intervention and school services.
	Skilled nursing care	No Charge	Not Covered	Limited to 60 days per Calendar year. Prior Notification is required for certain services.
	Durable medical equipment	50% co-ins	Not Covered	Prior notification is required for items more than $1,000.
	Hospice service	No Charge	Not Covered	Limited to 360 days per Calendar year.
If your child needs dental or eye care	Eye exam	$25 copay per outpatient visit	Not Covered	Limited to 1 exam every year.
	Glasses	Discounts for frames and lenses	Not Covered	Discounts for frames and lenses.
	Dental check-up	Not Covered	Not Covered	No coverage for Dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

• Cosmetic surgery • Dental Care (Adult/Child)	• Long-term care	• Non-emergency care when traveling outside of the U.S. • Private-duty nursing	• Routine foot care • Routine hearing tests • Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

• Acupuncture • Bariatric surgery	• Chiropractic care • Hearing aids	• Infertility treatment	• Routine eye care and glasses

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the Member Service number listed on the back of your ID card or visit www.myuhc.com.

Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-638-0014.

Chinese (中文): **如果需要中文的帮助**，请拨打这个号码1-800-638-0014.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-638-0014.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-638-0014.

----------*To see examples of how this plan might cover costs for a sample medical situation, see the next page.* ----------

Summary of Benefits and Coverage: What This Plan Covers & What it Costs **Coverage for:** Employee & Family **Plan Type:** HMO

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,330
- **Patient pays** $210

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$10
Coinsurance	$0
Limits or exclusions	$200
Total	**$210**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,920
- **Patient pays** $480

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$400
Coinsurance	$0
Limits or exclusions	$80
Total	**$480**

Questions and answers about Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied to the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.
- If other than individual coverage, the Patient Pays amount may be more.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No**. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes**. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes**. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-800-638-0014 or visit us at welcometouhc.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf or call the phone number above to request a copy.

Kaiser Permanente HMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.kp.org or by calling 855-249-5018.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$3,500** person/**$9,400** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges (unless balance-billing is prohibited), and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of plan providers, go to www.kp.org or call 855-249-5018.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use plan **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$5/visit	Not covered	Waived for children under age 5
	Specialist visit	$5/visit	Not covered	——————none——————
	Other practitioner office visit	Acupuncture: $5/visit; Chiropractic Care: $5/visit	Not covered	Limited to 20 visits/year
	Preventive care/screening/immunization	No charge	Not covered	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	——————none——————
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kp.org	Generic drugs	Plan Pharmacy and Mail Order: $5; Participating Pharmacy: $15	Not covered	Up to a 60-day supply; Up to a 90-day supply for 1.5 copays. No charge for women's preventive contraceptives.
	Preferred brand drugs	Plan Pharmacy and Mail Order: $5; Participating Pharmacy: $15	Not covered	
	Non-preferred brand drugs	Plan Pharmacy and Mail Order: $5; Participating Pharmacy: $15	Not covered	
	Specialty drugs	Applicable Generic, Preferred, and Non-Preferred copayments	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$5/visit	Not covered	——————none——————
	Physician/surgeon fees	No charge	Not covered	——————none——————
If you need immediate medical attention	Emergency room services	$50/visit	$50/visit	Waived if admitted as inpatient
	Emergency medical transportation	No charge	No charge	——————none——————
	Urgent care	$5/visit	$5/visit	Non-plan providers are covered only outside the service area
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Emergency admissions covered for non-plan providers
	Physician/surgeon fee	No charge	Not covered	Emergency services covered for non-plan providers

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$5/visit	Not covered	No coverage for psychological and neuropsychological testing for ability, aptitude, intelligence, or interest
	Mental/Behavioral health inpatient services	No charge	Not covered	——————none——————
	Substance use disorder outpatient services	$5/visit	Not covered	——————none——————
	Substance use disorder inpatient services	No charge	Not covered	——————none——————
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	After confirmation of pregnancy
	Delivery and all inpatient services	No charge	Not covered	——————none——————
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	——————none——————
	Rehabilitation services	Inpatient: No charge; Outpatient: $5/visit	Not covered	Outpatient: Limited to 30 visits of physical therapy or 90 consecutive days of occupational or speech therapy/year/injury, incident or condition
	Habilitation services	Inpatient: No charge; Outpatient: $5/visit	Not covered	For children under age 19 with a congenital or genetic birth defect
	Skilled nursing care	No charge	Not covered	Limited to 100 days/year
	Durable medical equipment	No charge	Not covered	——————none——————
	Hospice service	No charge	Not covered	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	$5/visit	Not covered	————————none————————
	Glasses	No charge	Not covered	1 pair of glasses/year limited to single or bifocal lenses or 1st purchase of contact lenses/year or 2 pair/eye/year medically necessary contacts (from select group of frames and contacts)
	Dental check-up	$30/visit	Not covered	Copayment applies to preventive services. Discount fees apply to other services

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture (20 visits/year)
- Bariatric surgery
- Chiropractic care (20 visits/year)
- Dental care (Adult)
- Hearing aids (Under age 18: 1 per ear per 36 months)
- Infertility treatment
- Routine eye care (Adult)
- Weight loss programs

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the plan at 1-855-249-5018. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, contact the plan at 1-855-249-5018. You may contact your state insurance department, or the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the State's Health Education and Advocacy Unit of the Consumer Protection Division Maryland Office of the Attorney General, Health Education and Advocacy Unit at 1-877-261-8807 or www.oag.state.md.us/Consumer.HEAU.htm.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **Coverage under this plan qualifies as minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.**

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 855-249-5018 or TTY/TDD 1-301-879-6380

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 855-249-5018 or TTY/TDD 1-301-879-6380

CHINESE: 若有問題：請撥打855-249-5018 或 TTY/TDD 1-301-879-6380

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 855-249-5018 or TTY/TDD 1-301-879-6380

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

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